CASE STUDY SERIES 2

HEALTH WORKERS IN FUNCTIONAL RELATIONSHIP WITH OTHER HEALTH RELATED WORKERS IN A VILLAGE COMMUNITY

- A CASE STUDY

राष्ट्रीय स्वास्थ्य एवं परिवार कल्याण संस्थान
NATIONAL INSTITUTE OF HEALTH AND FAMILY WELFARE
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आरोग्यम् मुखमम्पदा

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Preface

The National Institute of Health and Family Welfare, with two main functions research and training as an apex body in the country, is called upon to provide high level technical support to the development of vast and varied research and training infrastructure in the field of health and family welfare.

There are 47 HFWTCs, 412 ANM Schools and 45 LHV Training Centres as on April 1, 1987 imparting basic and practical training to field workers providing health services at the community and the individual levels. The training, therefore, becomes an important factor determining the quality and effectiveness of services provided by around 66,412 Multipurpose Workers (M&F), 17,050 Lady Health Visitors, 3,94,038 Health Guides, 5,54,090 Trained Birth Attendants. An army of health workers as large as this interfacing the community at 98,948 sub-centres can always be a subject of study.

Sub-centre becomes the most critical service unit. There are several studies dealing with the functioning of PHCs and other services units above PHC. Comparatively, there are very little or practically no comparative studies describing the activities, problems, successes, failure, etc. of the sub-centres in the country. Realising this gap in our knowledge, the National Institute of Health and Family Welfare has decided to carry out a series of indepth case studies, of which this is the first, in the different States of the country.

Developed for use in various training programmes, this study is wholly field-based so that it provides workers a realistic and composite picture of sub-centre when it is used for training. It describes in detail how activities of the sub-centre are influenced by the PHC and the district administration on the one hand and by the people on the other. In this sense, the use of the case study in training is likely to better equip the sub-centre workers to play the link role between the health system and the community effectively.

It is somewhat long for use in teaching sessions. In order to use this study properly, it is suggested that the descriptive part may be distributed among the participants and discussed with them first and the second part dealing with the emerging issues, may be used by the instructors for guiding the classroom discussions of the students.

It is hoped this study will be of use in training programmes. The Institute will be grateful if feedback is provided by the users of this material so that future studies of sub-centres as part of the series could be improved and made more useful for the purpose.

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INTRODUCTION

India is committed to achieve the goal of Health for All by 2000 AD with Primary Health Care as the main instrument of action. Within the health organisation the direct responsibility of providing health care at village level is jointly shouldered by the health workers (male and female) located at the sub-centres. Their success lies in performing their roles, alongwith other village level functionaries like Dais, Anganwadi Workers, Health Guides etc. and the ties they make within the community.

Primary Health Care Services within a village are delivered through a team of workers at the sub-centre and workers at the village level with provision for direct referral linkages and supervision. In Punjab, the team consists of Medical Officer, Health Worker (Male), Health Worker (Female) and a Pharmacist at the sub-centre level and a Health Guide and Trained Dais at the village level. These workers constitute a functional unit to provide promotive, preventive and curative services to the communities in a group of villages included within the jurisdiction of sub-centre.

The Primary Health Centre (PHC) serves as the focal point from which supervisory control is exercised over these peripheral workers. On the other hand, the workers can come to Primary Health Centre (PHC) for assistance and guidance in relation to their problems. Each member of the health team in a Primary Health Centre consisting of Medical Officer (MO), Block Extension Educator (BEE), Pharmacist, Health Supervisors (M&F) and Computers etc. The Medical Officer-in-Charge (MO/Ic) therefore, has to play an important role in implementing the primary health care for achieving the goal of Health for All. Each worker has specific responsibility in the given area and for a population.

The health functionaries performing their job responsibilities at Primary Health Centres, sub-centres at village level to the degree of satisfaction as expected of them make a lot of impact on the community whom they serve. The present indepth study is of two sub-centres villages of District Ropar in Punjab, one of the sub-centre being under Integrated Child Development Services Scheme (ICDS).

It has been observed that due to overlapping of health-related activities performed by other workers in the villages, health workers are often not clear in their perceptions about their own specific role. This sometimes leads to role conflict. The quality of performance and interpersonal relations and cooperation within and outside the organisation are also adversely affected. A thorough understanding of the problems of the health workers and health-related workers of other sectors (like ICDS) in the village community is necessary. The interface between various categories of village health workers and workers of non-health agencies doing health-related functions in a village was studied to identify and analyse the areas of cooperation, to resolve conflicts in promoting particularly MCH and family welfare services at village level. The interpersonal relationship between health workers and their supervisors at sub-centre and PHC level, the support provided to them and their linkages with each other were also studied. The other important factors contributing to health care promotion relating to participation of community in health activities of the villages were also studied.

The main problems sought to be answered through this case study are as under:

i. Whether the socio-economic and cultural profile of the village has a bearing on health and family welfare beliefs and practices of the community?

ii. How does the health system operate within the village community?

iii. How far the community is playing leadership role in the field of health activities for initiating and solving health problems?

iv. What forces are there to facilitate or restrain the performance of health activities in the village community?

v. How is the intra-sectoral and inter-sectoral coordination at village level the interface among village level health functionaries and the community operating.

METHODOLOGY

Methods for Collection of Data

Case study method was opted to find out the behaviour patterns of the personnel of two sub-centres in relationship with the village community which they served. The complexity of operative factors within a sub-centre was sought to be understood in the light of the desired objective of promoting an integrated health care systems. Through a skilful handling and interpretation of case study data, an attempt has been made to find the insight into cultural conflicts and problems born out of the change process.

Observational, statistical and official recorded data, have provided the scope for cross checking and assessing their consistency. Repeat interviews were also done with a few important respondents to ensure reliability of data.

As investigators our interest was directed to procure comparable data and persistently searched for the similarities or uniformities and deviations. Specific case situations do not constitute a sufficient description for understanding human behaviour. The cases under study can be regarded as possible examples of live situation, a good enough reason for other researchers to develop new insights.

The techniques adopted for collection of case study data were:

a. ***Focussed interviews***: The interviews were focussed on important issues related to primary health care services. The interviewers had complete freedom to decide the sequence in which the questions were to be asked to explore the interviewees and their motives.

b. ***Participant observation***: Through close observation of facial gestures and manner of emphasis of the informants reliability of response was also checked and wherever there was doubt clarification was sought and responses were cross checked. Face to face contact provided enough stimulation to the respondent to probe deeper within himself.

The situations were observed and understood from different angles and

whenever reasonable clue or doubts warranted, a stock of the observational data were taken that appeared to be important at different points of time. Observers were prepared to attend to clues from unanticipated events in an attitude of alert receptivity.

Findings and Observations

The findings presented here related to the health situation in the two sub-centres villages in different PHCs of a district in Punjab. One of these sub-centres is under ICDS Scheme. The role and functions of various village level health functionaries and their inter-relationship with the villlage community on delivery of primary health care have been thoroughly studied.

The case study has been developed on the following aspects:

1. The profile of the sub-centres and villages;
2. The sub-centre and village health facilities;
3. Availability of health functionaries at the sub-centre;
4. Coordination amongst different health functionaries and functionaries of other health-related sectors;
5. Role of private practitioners in the village health care and referral system;
6. Performance of health functionaries;
7. Community participation;
8. Look into the records.

The Profile of the Sub-centres and Villages

The Sub-centres: Both the sub-centres selected are in Kharar Block of District Ropar. The sub-centre Sajanpur (SC 'A') is a non-ICDS sub-centre. The total population of this sub-centre is 6,231. It is 14 kms. from Chandigarh and comes under PHC Masudpur. Sub-centre Nayarangarh (SC 'B') comes under ICDS Scheme. The total population covered by this sub-centre is 5,923. It is 8 kms. from Chandigarh and comes under PHC Halol. Sub-centre 'A' covers twelve villages while the sub-centre 'B' covers eight villages. The distances of the village from the sub-centre vary from 1 km. to 18 kms. in sub-centre 'A' and 2 kms. to 10 kms. in sub-centre 'B'. The population ranges in villages from 80 to 1,551 in sub-centre 'A' and 151 to 1,696 in sub-centre 'B'. Sixty-six per cent of the villages in sub-centre 'A' have a population below 400 whereas sub-centre 'B' has 37 per cent of such villages.

Village Profile

Village Sajanpur (A) has a total population of 1,551, with 201 households. The village Narayangarh (B) has a population of 1,696 with 280 households. The villages have the following caste-wise breakdown.

CASTE-WISE DISTRIBUTION OF POPULATION IN VILLAGES 'A' AND 'B'

Castes	Village 'A'	Village 'B'
1. Harijan Sikhs	575	530
2. Jat Sikhs	289	45
3. Mehera	272	135
4. Sainis	265	45
5. Gaderria	90	25
6. Carpenters	25	28
7. Lohar	20	18
8. Pandits/Brahmins	15	225
9. Rajputs	-	620
Total	1551	1696

It brings out that both the villages have large Sikh population but in village 'B' the Rajputs are a major dominant community.

Out of the 1,551 population 425 are children in village 'A' and 489 out of 1,696 in village 'B'. Their agewise break up is:

AGEWISE CHILD POPULATION

	YEAR									
Village	Upto 1%		1-5	%	5.14	%	14	%	Total	%
A	32	4.0	151	20.0	272	36.0	303	40.0	758	100
B	-	0.0	188	30.1	301	36.5	335	40.5	824	100

There are 222 eligible couples in the village A in 201 households, whereas in village B there are 245 eligible couples in 280 households.

Village Health Facilities

Both the villages, located on the road side, are connected with an approach road from Chandigarh, with to and fro bus services being regularly available.

Although the houses inside are seemed to be clean, the front of the houses presents unhygienic look. Villages do not have a common latrine. Open defecation is

common in the villages. Children could be seen defecating in the streets and open places and by the boundary walls of public buildings.

Each of the village has two wells, which are used for purposes of drinking water. Stagnant water standing around the wells could be seen as a result of clothes being washed at the wells.

The village 'B' in addition has a big pond close to the sub-centre building with stagnant dirty water. It is being used for bathing of animals and washing of clothes. Harijan and backward people of villages also take bath there.

Streets are paved with bricks but there being no drainage system, water and refuse can be seen scattered everywhere.

There are no sweepers in both villages, who could clean the streets, public places and surroundings. Filth was scattered all around the bastis. Panchayats have also not made any such arrangements for cleaning the streets and public places.

In village 'A' various communities were living in harmony. Though the Sikhs and Harijans are in minority yet Sarpanch was a Sikh and all the community leaders support him.

In village 'B' the community is clearly divided in two bastis, one belonging to Harijans and the other belonging to Rajputs. The Sarpanch was a Rajput and the leader of his group. The Harijan basti is represented by one of the panchayat members, popularly known as Masterji, a prominent leader of Harijans and backward classes.

In village 'A' there are Government high school and primary schools, having pucca building and sufficient staff. Their surroundings are very neat and healthy. In village 'B' only one primary school is located in a remote corner of the village. Its surroundings are poor and insanitary. The attendance of children in the school of village 'B' was very thin, but in village 'A' it was good.

The sub-centres in both villages do not have their own buildings. They are located, in village 'A' in one small room of Harijan Dharamshala and in village 'B' in an out-house room of a village temple. There are no sign boards outside the rooms, giving any indication about the sub-centres. Inside the rooms there are chairs for doctors and pharmacists, a stool for examining the patients and a bench for patients/visitors. In sub-centre 'A' an examination table made of steel without any mattress was lying behind the doctor's chair but in sub-centre 'B' it was not there. No proper screens were provided to permit privacy for examining the patients. In sub-centre 'A' at a little distance a separate katcha room is provided for Health Worker (Male and Female). The room is mostly found locked and its keys are kept with the Health Workers themselves. In sub-centre 'B' even this facility does not exist and the workers share the space with the doctor.

The sub-centre building in village 'A' is located at the entrance of the village on the road side. The rooms are semi-pucca with no electric connection. The accommodation is made available only during the day time. Later the sub-centre's furniture and material are put in corner or removed to safe place by the Sarpanch for holding social functions there. This sub-centre is quite open but not kept neat and tidy.

The only health facility in the village 'B' is the sub-centre. It is located on the outskirts of the village, with very poor muddy approach from the village. It has no electricity, no provision of public facilities like bathroom or water pump. At night labourers use this room for sleeping purposes. Every time the team visited the centre the doctor was found to be holding the clinic outside the room, with no arrangement for examining the patients.

The staffing pattern of both the sub-centres is almost the same. It consists of a Medical Officer, a Pharmacist, Health Worker (M) and Health Worker (F) and two Peons. In sub-centre 'B' the post of Pharmacist is lying vacant. The other categories of indigenous health workers available in both the villages include trained dais (5), health guides (5), medical practitioners (2 and 3) and 1-2 Mahants (traditional healer). Their total number in both villages is 14 each. Village 'B' being ICDS sub-centre has two Anganwadi workers as well.

One trained dai is available in each sub-centre village. Three private practitioners in village 'A' and two in village 'B' also provide medical facilities to the villagers, under both (Indigenous System of Medicine) and modern system. Private practitioners in either village are not qualified medical persons but are registered as medical practitioners. They have well maintained clinics with adequate furniture, and electric fittings. Their stock of medicines and injections can be seen on the table, open shelves and in glass almirahs. Their clinics provide neat and clean environment and whenever the team was around their clinics, two or three patients were always found sitting with them.

At both the sub-centres, clinics were not being held regularly. The entire staff was never found at the sub-centres between any fixed hours. They had no schedule of work. It was found that when the health workers were there, the doctor/pharmacist was not around. The patients had to wait for long and return without getting care. During the week, it was found that hardly three or four patients visited sub-centres daily. On an average, attendance per week has been 10 to 15 patients as per records. The staff, including the peons, at both the sub-centres were not staying in those villages, except one health worker (M) in village 'B'. Mostly they were residing in Chandigarh and Mohali.

Sub-centre 'B', covered also under ICDS Scheme, has two Anganwadis: one in Rajput basti and the other in Harijan basti. The two Anganwadi workers help in promoting child health care and pre-school education among children in the village. A fixed day for the immunization of children on that day the sub-centre team visits Anganwadis and organises immunization programme. Rajput basti Anganwadi is located in a private house in the heart of the village. It is well maintained in a very neat and clean environment. The other Anganwadi is in the Harijan basti, located in the verandah of a Gurudwara. Its surroundings are also equally good. Both the Anganwadis had facilities like furniture, kitchen and educational equipments. These centres get sufficient and regular nutritional supply. Arrangements for cooking and distribution of the food to the children are good. Since both Anganwadis are located in the heart of the respective bastis, they are easily accessible to women and children of the community, for participation in all the activities. Rajput women's participation is poor as they observe purdah rigidly.

The records of Anganwadi workers of both the centres are very well maintained and uptodate. Both Anganwadis cater exclusively to specific communities and do not coordinate or share among themselves. It is relevant to mention that one of the Anganwadi workers is highly dedicated and has been regularly visiting her Anganwadi on her own moped. She was doing her work with a missionary zeal.

The other important village functionary related to health is the Chowkidar. He maintains the records of vital statistics. In both the villages under study registers showed uptodate entries regarding births and deaths. One copy of the recorded information was sent to the police station, the other to the concerned family and the third was retained for records. Both the Chowkidars were performing their duties excellently.

SUB-CENTRE AND VILLAGE HEALTH FACILITIES

Working environment makes an impact on the functioning of health staff. A good building at the sub-centre would contribute to it. The present buildings of the sub-centres adversely affected both the providers and consumers of services. The contrast becomes critical with the differences in available facilities of other government agencies functioning in the same village. Unfortunately, the health and sub-centres have no building of their own and are located in insalubrious conditions under which the health staff work. The following few significant statements of the village leaders and health functionaries obtained through participant observations and indepth interviews evoke a common concern for the same, but they express different views about who can do what and how much.

WHAT THE PEOPLE SAY?

"With great difficulty and efforts we were able to get the sub-centre for our area. A room of the Harijan Dharamshala is being used for the purpose. Panchayat has allocated the land but it has no money to provide for the matching grant. Panchayat would never have money nor the sub-centre will ever be built". "Would you not recommend to the government to construct the building".

(***Community Leader 1 'A'***)

"In the village much depends upon the Sarpanch. Panchayats have enough funds. Matching grant from the government prevents the Sarpanch from having a free hand in spending the government money. Therefore, he is not interested in the construction of the building".

(***Community Leader 2 'A'***)

"I being Sarpanch have given the land for the construction of the sub-centre. I am not getting any cooperation from the Health Department nor I expect in future. We have been left to our lot. Notionally, we have a doctor but he attends the MLAs hostel only. Who bothers for the poor villagers? We have a community Dharamshala belonging to the Harijans. They have honoured my words by providing a room temporarily for the sub-centre clinic, but it is pharmacist who is generally there.

Panchayat could afford nothing more for the purpose of construction".

(*Sarpanch 'A'*)

"What a pity? It is functioning in the room attached to the temple. How dirty, this back room of temple is? It is also shared by the labourers, who halt in the night and it cannot be locked as it opens in the back verandah".

(*Youth Community Leaders 'B'*)

"We have two Anganwadis in this village. How well maintained those are? They have good environment. Unfortunately our sub-centre is very shabby. We do not feel like sitting there. Sarpanch has no concern for the health care of the villagers. He only appears when he has to get votes. I feel if Sarpanch takes due interest we can construct a good building for the sub-centre also. Earlier our Master Sahib independently raised donations for the village and got the road paved in the Harijan basti". If the Sarpanch wants he can do.

(*Community Leader 'B'*)

"Our Sarpanch is a Rajput and very non-cooperative. His role is always destructive. He has no concern for any type of development including construction of building for sub-centre. It is the responsibility of the Panchayat to arrange for the land and building for the sub-centre. The BDO has already provided bricks for Rs.5,000 for the pavement of street roads. You can see the heap lying over there near his house. There is a lot of conflict in the community. Therefore, no work is being initiated by him. We are sick of this Sarpanch and his associates. We women folk have no voice and cannot force these male folk for doing better things. We have become quite helpless".

(*Lady Panch 'B'*)

THE VIEWS OF HEALTH STAFF

What a contrast to the sub-centre is the government school building. The headmaster of the close by school has got beautiful building with all facilities. You can well imagine how much demoralised we doctors feel".

(*M.O. Sub-centre 'A'*)

"Most of the new sub-centres are established on political considerations with no building and other amenities. You, yourself, can observe and imagine how I have to work with my team in such a dirty, unhygienic environment. The people of this area are least cooperative. After much persuasion, the Panchayat agreed to erect a boundary wall of mud but it could not stand even one rain. A temporary extension of electric connection has been given. We do not have even a sweeper to clean the room. I do not know whether the government or the Panchayat has to construct it but we have to suffer".

(*M.O. Sub-centre 'B'*)

"Village community wants a doctor who should be regularly available all the time and in emergency as well but who will provide the building? Neither the government nor the community has the will to do so".

(*M.O. PHC*)

"See the condition of this sub-centre. It is in a room of the Dharamshala. It is partly plastered and partly furnished. There is no electricity, no water arrangements and no provision of toilets. How can we make our young doctor work in these centres? Villagers want the doctor to be there but are unwilling to give facilities. What is the matching grant business? We know that the community cannot afford it. It is better not to establish a sub-centre like this. We need a firm planning regarding opening of the sub-centre".

(*B.M.O.*)

"The sub-centres are opened on pressures and other considerations. Inspite of our best efforts the Panchayats did not come forward with the matching grant. Their funds are meagre. Therefore, the construction of building gets unnecessarily delayed. We feel sorry to put our doctors to work in such nasty conditions but there is no way out. Look at these sub-centres. How our doctors are sitting in these dingy rooms of either a mandir or a dharamshala? There is not even the basic amenity like electricity, drinking water, toilets, etc."

AVAILABILITY OF HEALTH FUNCTIONARIES AT THE SUB-CENTRE

The provision of primary health care in the village community, even in the absence of adequate facilities and building, can be organised effectively provided the health functionaries attached to the sub-centre visit their area regularly and the doctor is available atleast during the working hours. The situation regarding availability of different health functionaries in both the villages under study is revealed from the following:

"The doctor is not coming to the sub-centre most of the time. He never visits the village community. No other health functionary is even available in case of an emergency. We have to depend on and rush to Chandigarh hospital. But it is very costly."

(*Community Leader 'A'*)

"Honestly speaking, health workers only show their faces at the sub-centre. For the past four to five months no health worker (male) has ever visited this village. The earlier male worker used to come regularly and enquired about our welfare. Why public money is being wasted on payment of salaries to the health staff when we are not getting any service from them?"

(*Women Leader 'A'*)

"These days people have lost all faith in the sub-centre staff. The present doctor claims to be on duty at the MLAs Hostel in Chandigarh. He visits the sub-centre at

his own sweet will. If at all he visits he is showing mercy to us. Other staff also are as free as the doctor. Mostly the other staff visit on rotational basis. Most of the time the peon or the pharmacist act as our sub-centre doctor. They only are there to attend on us".

(***Community Leader 'B'***)

"Which staff you are asking for. I have atleast not seen any regular health staff coming to the sub-centre and serving the village community. We have no choice except to seek the help of private practitioners. They are the only doctors available for us".

(***Community Leader 'A'***)

"The doctor is not regular. I have to do his job also. I advise the serious cases to go to government hospital but community did not like it. They quarrel with me. They do not believe that I am not a doctor. They want me to treat them. In the process we loose the patients visiting our centre. Referred cases feel hurt. They curse me and the other sub-centre staff, because I am only there to face them. I provide them available basic medicines, which they do not like".

(***Pharmacist 'A'***)

"Meeting the doctor at the sub-centre is a matter of chance. The sub-centre never has the required medicines to provide. Even if the doctor prescribes, the poor villager has to go to city to purchase it from the chemist. No villager is sure whether the doctor will be available in the sub-centre. Once a lady who got pregnant after a tubectomy operation sat for the whole day to get advice of the doctor as he had operated on her. The poor lady came continuously for the whole week but the doctor on duty was never available. He is always busy with MLA Hostel. He never bothers about us and the villagers. In your presence the husband of the lady is abusing me because I motivated her for the operation. What loose words he is using for the doctors. It shatters our respect too. I could only wish that some other doctor may be posted to this centre, otherwise we shall have to face such repeated embarrassments".

(***Lady Health Visitor 'A'***)

"In the morning from 9-11 a.m. I regularly sit in the sub-centre and hold the clinic. I provide treatment for the minor ailments, ***i.e.*** fever, loose motion, vomitting, anaemia, etc. My lady supervisor regularly visits the centre on EPI day. The sanitary inspector also comes along with her on that day to collect blood slides and provide DDT for village wells".

(***Health Worker (F) 'A'***)

"Whenever I visited this village, I was able to contact Health Worker (F). Rarely, could I meet the doctor. We mark our attendance separately in a register which is available to both of us".

(***Health Worker (M) 'A'***)

"I stay in the village. Whenever LHV visits the centre she calls me. I assist them on EPI day in calling mothers from their homes and help in sterilising the syringes, needles and preparing tea for her".

(*T.B.A. 'A'*)

"About the doctor of the sub-centre, only God knows when he will be available. Despite my best wishes I could not meet him to invite even at the time of Bhog Ceremony of my grand father. Health Worker (M) and Pharmacist came but the doctor never did".

(*Sarpanch 'A'*)

"I do not know what is this scheme of posting a doctor at the sub-centre, when none is available there. We, the poor villagers are being befooled. Since doctor does not attend, the other health workers, who used to visit the village earlier have also stopped coming there. They could be seen for a while at the sub-centre. Whom should we approach for these problems? Kindly report to the authorities".

(*A Villager 'A'*)

"Whenever I have visited, most of the time, this centre had given a deserted look. I find only a peon or a compounder sitting there. Hardly you get any other health personnel. Where they go or remain is not in our knowledge. They do not stay here in the village and no supervisor has ever visited the sub-centre. They come from Chandigarh. If bus misses the morning trip, you find the sub-centre locked for the day with nobody bothering about the duty. For what should we then come to the sub-centre? We have to depend on the private practitioners. Would you in any way help us?"

(*Community Leader 'B'*)

"Only sometimes the doctor appears on his scooter in early hours. He hardly stays for an hour or so and then slips away. We, the villagers are most busy in the morning. By the time we are free to visit the sub-centre, there is hardly any staff to attend on us. The centre generally remains closed without any notice to us. Sarpanch never bothers for it".

(*Community Leader 'B'*)

"Health Worker (M) stays in the village. He is only available to us. The Health Worker (F) comes once a while in a fortnight. The doctor is also sometimes available in the morning hours. The Pharmacist is absent for the last 2-3 months. Nobody is bothering to post a substitute. We have no doctor to call upon during emergencies specially at night. Even private practitioner does not stay in the night".

"Male worker performs his duties regularly and nicely and is always available. About the others I cannot say much. I do not know which lady health worker you are asking for?"

(*Women Leader 'B'*)

"Health Worker (M) makes home visits and educates us. Only once I came to the sub-centre two months back to take medicines for my ailing child but to my surprise I did not find the doctor. I told Sarpanch to report to health officers but it was of no use. There I met that day a lady doctor the Health Worker (F). She enquired about the number of children I had. I told her that it was my 10th child. She advised me for operation. I was stunned. Earlier no female worker dare to talk with the male folk of the villager for vasectomy operations. However, I was so embarrassed by her querry that I soon got operated. I feel that if dedicated and daring workers visit and educate us, things will be better".

(***Community Member 'B'***)

"I make weekly visit to the sub-centre on EPI day. I have not met the doctor in my past four visits. As I stay in Mohali and have to depend on the buses, most of the time is spent on the journey. There is little time to do home visits and follow-up in the villages. But I hold the clinics at the sub-centre only".

(***Lady Health Visitor 'B'***)

"I attend the clinic in separate building and then visit the village. My supervisor ***i.e.*** LHV comes on EPI days only. She does not go inside the village. Health Worker (Male) has rarely come to the centre during the time I was present".

(***Health Worker (F) 'B'***)

"It would be very useful for me and the villagers, if the sub-centre staff also visited my village. But unfortunately no staff visits. The HW (F) has never helped me in conducting delivery in the village. Once I fell sick but sub-centre doctor did not visit despite my message to him. If I could not get his services who else in the village would get it".

(***T.B.A. 'B'***)

"Village Community needs a doctor who should be regular and available at all times. The condition of a sub-centre is so poor that no Medical Officer would ever like to stay there. The doctor particularly is never available. People have complained and are losing confidence in health services. They prefer to call on RMPs. It is better to close such centres".

(***B.M.O.***)

COORDINATION AMONGST DIFFERENT HEALTH FUNCTIONARIES

Within the health sector often a number of non-governmental and governmental agencies are functioning to cater to the health needs of the community. This may include voluntary organisations, private practitioners, traditional health workers and workers of education, social welfare, police, revenue and community development departments etc. An effort was made to determine how these are linked and coordinated to determine for effective performance of health care activities in a sub-centre.

In addition to the health sector, the activities of other developmental sectors are also likely to influence the health promotion of individual and the community. There is a necessity to develop close functional linkage between the grassroot workers of health and other sectors, so that activities performed by each of them are complementary and they work in an integrated way. The views of various categories of workers reported below are indicative of the extent of coordination and cooperation among them:

"The Chowkidar of the village is very cooperative. He maintains uptodate records of birth and death with the help of his son. Whenever we ask, he provides complete data. He is unable to see, as he is too old and has developed cataract, yet he does his job well. He visits the dais and Sarpanch very frequently to know about births and deaths and registers every birth and death".

(***Health Worker (M) 'A'***)

"The motivation for acceptance of family planning methods by health workers alone now does not work. The influence of other non-health agencies like Police Inspector, Tehsildar, Block Development Officer are used by the Chowkidar, Patwari and Gram Sevaks to prevail upon the community. As such, though we do ground work for family planning, but do not get the least credit for achieving the targets in our area".

(***Health Worker (M) 'A'***)

"Whenever Lady Health Visitor visits my sub-centre, she guides and helps me in providing family planning services like Oral Pills and insertion of Copper T. She always visits homes of the pregnant mothers registered at the sub-centre alongwith me and provides the iron and folic acid if I have a shortage. I do not have my own independent tour programme. Actually, I mostly depend on Health Worker (M). He helps me a lot in maintaining all the records. In this village I get all assistance from the trained dai for family planning motivation and registering mothers and children for immunization".

(***Health Worker (F) 'A'***)

"Three months back there was a family planning camp. Gram sevak, Patwari and BDO all came to my village for motivational campaign. The Medical Officer of the sub-centre asked the Health Workers (male and female) to accompany them. These workers provided all support to the workers of other departments.

Finally, after a week, those female cases willing to undergo sterilization assembled in the sub-centre. They were to be carried to the PHC for tubectomy operations. In the meanwhile the functionaries of other departments had an open fight between them for the number of motivated cases to be registered against their names. Each one wanted a lion's share. The cases which were motivated by Health Workers (male and female) were dragged by them. Finally, I had to intervene and asked the women gathered there to declare which functionary had motivated them and they would like to accompany with for sterilization. The females felt much embarrassed. They told that they would go with the Health Worker (F) and Health

Worker (M) only. They were subjected to all sorts of harrassment by the functionaries of other departments. It was realised by the Medical Officer that health workers at grassroot level, the trained dai and health workers (male and female) who had spent their time and energy for motivation were totally helpless before these functionaries of other departments and their seniors. I advised the Medical Officer to keep silent. The health staff just remained silent spectators and the cases were forcibly carried away by the workers of influential departments like Gram Sevak, Patwari etc. It was a show of power and was embarrassing for the women folk of this village. What cooperation do you expect in future? Achieving family planning targets have become everybody's job. This target completion business has caused conflict among the Medical Officer, Tehsildar and BDO. As a protest the sterilized cases were not properly followed up and looked after by HWs as they did not get any credit for it. This rift has totally disturbed my relationship with community and demoralised the health workers of the sub-centre. Now the doctor does not care about me as well".

(*Sarpanch 'A'*)

"I am running this anganwadi centre for the last two years. I am getting all support from my supervisor. From sub-centre ANM and LHV visit us the day there is immunization programme for children. I am maintaining my records uptodate. The village trained dai and LHV otherwise rarely visit my centre. No worker of any other department ever visited us. I know about adult education instructor and school teacher in the village. They have never sought any help from me nor given me any help. I hardly require anybody's help. The worker of the other anganwadi is a local lady. She is very cooperative. We frequently meet each other but because of different and rivalary between two groups of community, we are not able to organise any joint programme. You see that despite your desire to hold a joint function of both the Anganwadi, ultimately you had to do it separately for each of the two.

(*Worker of Anganwadi 'B'*)

ROLE OF PRIVATE PRACTITIONERS IN THE VILLAGE HEALTH CARE AND REFERRAL SYSTEM

Village Health Care

The private practitioners need to be integrated with the organised health services and the health system of the country. But lack of coordination within the health sector, between the private practitioners and the health functionaries poses threat to each other. However, due to apathy of the sub-centre/PHC medical officers towards the rural community, private practitioners find larger acceptance in the community. Moreover though the government supports the philosophy of providing primary health care to the vulnerable and weaker sections of the society, it is hardly seen in practice. The facade of preventive and promotional services at the cost of curative services does not carry the health services too deep in the community. Peripheral institutions and workers have been able to provide curative services to the selected group of village elites. The poor people in the village are given no attention. They approach private practitioners of all shades who are providing some sort of medical care within the reach of the community. Moreover,

that the Medical Officer of the Centre does not attempt to integrate these practitioners in the village community is evident from the following statements:

"For the last five years, Ayurvedic system is in practice in the village during day hours. In the evening I sit in the next close by village. I attend to about 15-20 patients/cases in each village every day. The village ladies are more frank with me than with the health staff of the sub-centre. Often the male health worker seeks my help in motivating ladies for family planning. Once a lady's son who had recently been immunized ran very high fever. The health worker told her it was because of immunization and the fever would abate in day. The poor mother came to me for treatment of the child. It was a case of enteric fever and the child had been immunized in that condition. I do not know whether the DPT was given in this condition. After a week of treatment the child was cured. I wanted to consult the doctor of the sub-centre. I could not find him during that week. Many ladies ask me to provide oral pills but I never get it from the sub-centre for distribution, because I could not contact either the doctor or any of his staff as they do not regularly visit the village".

(***Private Practitioner 'A'***)

"When we are sick or have some trouble we are not sure about the presence of the doctor in the sub-centre. We have to be on the mercy of these private practitioners alone. Therefore, our people prefer to approach these private practitioners first. The drugs are easily and quickly available with them. They provide all services under the same roof. Moreover, we do not have to wait, or to walk the distances and also get the injection if required for quick recovery, or in emergency.

(***Community Leader 'A'***)

"Often we go for medical aid to private doctor at Kharar 30 kms. away from here. The Medical Officer of this sub-centre is never available. The private medical practitioner has all facilities, ***i.e.*** injection, capsules, etc. which give quick and positive results. People have developed faith in them for certain diseases, ***Mahantas*** have better treatment and people approach them too. I have also learnt it. It is effective for the gangrene of fingers, a common disease in this area. Even cases which could not be cured at general hospital and by private doctors have been cured by ***Mahantas***. I have also learnt from ***Mahanta*** and cured about 100 such cases. You can talk to the community in this regard. There is another person in the nearby village who is also very popular for curing the cases of snake bite. We seek his help when required. Sub-centre/PHC doctor has no cure for it".

(***Community Leader 'A'***)

"Patients feel hurt if I recommend serious cases to PHC or General Hospital. People do not like it. They want that we should provide them immediate care. They ask for the injection otherwise they feel that they are not being treated and prefer to go to the private practitioners. There are a few private practitioners in this village who treat by giving injections and provoke the community against the treatment given by sub-centre staff as poor and useless. The private practitioners talk little about family welfare. Every sub-centre staff has to talk more about it and much less about other

health problems. This annoys the villagers. They feel encouraged to go to private practitioners to avoid listening about family planning".

(*Health Worker (Male) 'A'*)

"There are private doctors who have a good reputation among the villagers and are earning a lot. They have sufficient medicines with them to provide for. The people of the community regards both of us Health Worker (M) and Health Worker (F) as a doctor. But we have few medicines to provide for. We treat only minor ailments but community expects much more from us".

(*Health Worker (F) 'A'*)

"The sub-centre generally remains at the mercy of peon whom the very poor villagers consider as 'doctors'. He occasionally provides simple tablets and dressings to patients visiting the sub-centre. Those are villagers who cannot afford any private treatment. Helpless people alone visit the sub-centre".

(*Youth Leader 'A'*)

"People have a poor image of us. They regard private doctor better as he tries to give them immediate relief and attention. To improve the image of health staff the private practitioners should be banned in the villages. They exploit the illiterate people, provoke against health staff, do illegal abortion and exploit young girls and women in their villages. The village leaders and supervisors have been told but nobody has raised their voice against them. These private practitioners are staying in the village, mix up with the local leaders and are very much trusted by the village elite. It is difficult to ignore them and we have to give them due regards, despite our not liking them".

(*Lady Health Visitor 'A'*)

"In the absence of the regular availability of the staff of the sub-centre, the village community has to depend on private practitioners. There is no way out. They misguide our illiterate masses and create even hatred for and condemn the sub-centre staff and services. These private practitioners stay in the village most of the time and have developed good rapport and contacts with the villagers. As a result the people are loosing their faith in the sub-centre services and give due respect to these private practitioners though we have to pay for it".

(*Community Leader 'B'*)

"The private practitioners in this village have developed very intimate relationship with certain women folk and young girls. With their cooperation they conduct illegal abortions. They also sell smack and opium (Hashish) to village children. One of the child from Bassi village died on account of these drugs. Inspite of wrong practices people are still tolerating them because they do not have any other choice during the emergency situations".

(*Ex-Lady Panch 'B'*)

"The private practitioners generally practice modern system of medicines. They propagate injectable medicines for quick recovery. Sometime they give take and even wrong injects. In this village there are traditional healers also - known as ***Mahantas***. I do not have faith in them but since I am living in the village, and the community has belief in them, I have also to be with them. Perhaps people lack faith in God and in the doctor, otherwise they will never go to these ***Mahantas***, and waste their money. Unfortunately, the sub-centre doctor is never seen in the villages and for villagers ***Mahantas*** and RMPs are as good as qualified doctors. A friend in need is a friend in deed".

(***Community Leader 'B'***)

"Private practitioners have sufficient stock of medicines and injections. They provide injection on people's demand. Therefore, people prefer them. Male workers are not supplied with the medicine to be given to the patients. Therefore, people do not develop that faith in us. They rely more on the private practitioners though they are totally qualified".

(***Health Worker (M) 'B'***)

"The private practitioners discourage the villagers to visit the sub-centre. They provide injections for all diseases very frequently and villagers get highly satisfied. They regularly open their clinics and sometimes stay even overnight. The village community feels secure in the hands of such doctors. Last month, an old man suffered from acute diarrhoea. He came to the private practitioner in the evening. The case was serious. The practitioner attended on him for the whole night though he died. The people appreciate his efforts and prefer to visit the private doctor for immediate relief. How we can persuade the villagers to visit the sub-centre when we know that the doctor is never there".

(***Health Worker (F) 'B'***)

"Most of the patients who visit the centre are elderly ladies. They are illiterate and are crazy for injections. We cannot give injections to every patient and for every disease. As such they prefer to go to private practitioners, for whom injection is must for all diseases and they charge them heavily. I do not know why village people consider medicines provided by us ineffective as compared to injections given by private doctors. The private doctors have good time in villages".

(***Medical Officer, Sub-centre 'B'***)

"Generally our ladies visit the sub-centre for taking the medicines. As sub-centre staff do not visit regularly, I have to contact the private doctor for immunization of mothers and children in my village. The sub-centre staff unfortunately do not provide any help or support to me in conducting deliveries and giving tetanus toxoid to mother".

(***Trained Dai 'B'***)

Referral System

The success of primary health care lies in evolving an effective referral system. In a sub-centre where the doctor has been posted, the referral system from the field to the sub-centre and sub-centre to the PHC and above should have evolved and functioned properly so as to be a model for other PHCs. However, the chronic non-availability and lack of punctuality on the part of health staff including the doctor at sub-centre/PHC cuts at the very basis of development of the primary health care system.

Due to lack of regular out-patient departments (OPDs) and follow-up, no screening of cases is being done for referral to the PHC or above, though the team could observe serious cases of tuberculosis, exzema, malnutrition, blindness and complications of pregnancy etc. in the village. They remained unattended and neglected by the sub-centre staff. As stated by Sarpanch the only resource left to villagers was eihter to carry the patient to Hospital at Chandigarh or PHC if they could afford or to leave them to God.

The referral from the periphery to the sub-centre is also being encouraged by health worker as the doctor is generally not available. Some of the following significant statements make the situation obvious:

"I am very poor man suffering from tuberculosis. Health Worker (Male) told me to visit the sub-centre and see the doctor there. I was told that I will get free treatment. I went 3-4 times but I could never meet the doctor. I felt tortured and left myself to the mercy of God".

(TB Patient 'A')

"In case of emergency we rush to General Hospital, Chandigarh. No one likes to go to the PHC. It is no better than sub-centre. There is a trained dai alone in this village. In case of complications there is no other recource than to go 20 kms. away to the city general hospital. Once I had serious bleeding during my pregnancy. Dai was contacted. On her advice I went to Chandigarh".

(A Pregnant Women 'A')

"Whenever I refer any case to the Health Worker of the sub-centre, they give full attention and care for him. I feel proud and happy to work with them as a health guide to serve the community. But I have never got any support from the doctor. I referred a few cases to be examined by the doctor himself. He was never available, except once and even on that day he categorically refused to make a home visit and examine the patient in the village. Later he was treated by the private doctor. It was a case of Sarsam (delirium). The man died next day. It had very bad repercussion on my relationship with the villagers. Now they do not trust my words".

(Health Guide 'B')

"I am the village Chowkidar and serving this village for more than fifty years. I had been suffering from cataract which needs to be operated. I had been repeatedly requesting the doctor of the sub-centre to help me in getting cataract operation but

he has never paid any heed. Even today I requested the doctor to be sympathetic and to help me for getting my eyes operated. He snubbed me. Would you (the team) please help me in this regard? I am a very poor man. I had been serving the department but no one has cared for me".

"Meanwhile, listening to my conversation with the team, the Senior Medical Officer who had arrived at the moment instructed the Medical Officer sub-centre to send me with a slip to the eye surgeon in the next camp which was being organised during that week at the district hospital. I felt comfortable and relieved and thanked the Senior Medical Officer for her sympathetic act".

(***Chowkidar 'A'***)

PERFORMANCE OF HEALTH FUNCTIONARIES

The health functionaries are expected to promote primary health care by undertaking the following activities:

1. Education of people about health matters.
2. Promotion of nutrition education in the community.
3. Ensuring safe water and basic sanitation.
4. Promoting maternal and child care.
5. Promoting family planning programme.
6. Arranging immunization against major diseases.
7. Control of locally endemic diseases, like TB, malaria, leprosy, infection, diarrhoea etc.
8. Promoting inter-sectoral coordination and community involvement.
9. Treatment of minor ailments and referral of patient.

An effort was made to know from the health functionaries regarding their activities and performance which can be viewed against the expected performance of the sub-centre. The following descriptions suggest the extent of the activities being performed by the health functionaries at the sub-centre and village level.

Performance of the Health Functionaries

"I give treatment for minor ailments and provide medicines, which are issued to me by PHC. I prepare blood slides and distribute medicines for malaria. I am actually known as 'Chhoti Doctor' in my village. It gives me a lot of encouragement. I do motivation work and follow-up every month. I get drug replinshment from the Block Extension Educator. Health/Malaria Inspector also visits my village and supervises my work. I refer cases to the sub-centre where they get necessary care".

(***Health Guide (F) 'A'***)

"I have been working for the last six years as Health Worker (F) since June, 1985 I am posted at this sub-centre. I come and go by bus daily. I do not stay in the village. On arrival, I hold the OPD clinic. On average five to six patients attend daily. Today you have seen there are cases of fever, diarrhoea and loose motion. Yesterday was Wednesday. Every third Wednesday of the month I conduct Expanded Immunization Programme. From diary you can see that 16 mothers with

children came to attend with Trained Dai/Health Guide. On that day I regularly visit the village community for family planning motivation. I distributed Nirodhs/Oral Pills at home but I did not keep any record, except the diary. In the diary I wrote the number of the immunization cases attended. My eligible couple register is not uptodate and I have been advised to complete it. It is at my home. I have seven villages under me, but I do not have any independent tour programme. I largely depend upon Health Worker (M) and go to tour along with him according to his programme. For the last two months I did not visit any of the villages except this. I have prepared blood slides for malaria. Alongwith Trained Dai I want to follow-up the cases of sterilization in this village. So far I do not have much acquaintance with the health guides of the area. I do not know their names and even the names of trained dais located in other six villages. I did not get time to move in other villages because my daily travel to and fro Chandigarh took away my time. I only know local dai of this village she herself visits the sub-centre on her own".

(***Health Worker (F) 'A'***)

"I have ten villages under me. I visit those villages to provide services, relating to immunization, malaria, sanitation, health education, tuberculosis, blindness and family planning. I have a yearly calendar of activities on the movement in the field. Sometimes, when I visit these villages, the health worker (F) also accompanies me. I meet the health guide and trained dais of the villages also. On the days when I do not go to a village they visit families in the village community. These functionaries accompany us in the village and inform us about the health problems. There is much emphasis on the achievement of family planning targets. The senior supervisors including Medical Officer lays stress on it. Both I and Health Worker (F) have to work jointly for motivation. Generally we make a joint effort to achieve our target of family planning. But this time we would not perform weekly follow-up of all the sterilized cases".

(***Health Worker (M) 'A'***)

"I store and distribute medicine to the patients. Often I attend the OPD as well and prescribe when doctor is absent. There is hardly any attendance at the sub-centre as the doctor rarely attends. I always advise the serious cases to visit PHC. People prefer to go to the General Hospital rather than to PHC. It is more convenient for them as Chandigarh has direct bus route".

(***Pharmacist 'A'***)

"I stay at Mohali, 8 kms. off from Gharona PHC. Most of the time is spent in reaching the sub-centre from Mohali. I make weekly visit to sub-centre and also come on immunization day. I miss weekly visit when the immunization programme is held at any other sub-centre. I check the household and eligible couple registers. I visit four to five pregnant mothers and 20-25 homes on average in every sub-centre in every week. I also attend meetings at Senior Medical Officer Office".

(***Health Assistant (F)/Lady Health Visitor 'A'***)

"I know that everybody complains about my absence from the sub-centre. But I

can serve only at one place at a time. I feel happy to be there in MLAs Hostel as I get job satisfaction and can prescribe as I feel. Why should a highly qualified man waste his time by sitting idle and helpless in a village where there is neither facility nor equipments. I do not see any utility of posting a doctor at such sub-centres".

(***Medical Officer 'A'***)

"Jats and Sainis are in majority in this village. I am a trained dai, I provide services to the pregnant ladies of my village. I do follow-up of family planning cases and assist Health Worker (F), when she comes to my village for delivery, but it is very rare. I do not visit the sub-centre every month. When I visit sub-centre, I get full respect and guidance. Mostly I act as a link between the sub-centre staff and the village community. I would like that Health Worker (F) and Lady Health Visitor visit the village more regularly. I am very willing worker and am willing to provide them all cooperation".

(***Trained Dai 'B'***)

"There is no place to hold an independent OPD clinic which is expected of me. Health Worker (M) has his own tour programme. I do not have a joint tour with him, nor I prepare any joint tour programme to work in a team. Each one of us is independent. Health Worker (M) gets travelling allowance and I do not. So he makes his tour. Sometimes I do join him in motivation work. I have never called any group meeting in the village during my posting. I generally meet them individually in the village for motivation and education. I attend the EPI clinic and give immunization. Cases of tuberculosis and blindness if suspected are advised to visit Government Hospital, Chandigarh, for further check-up and treatment. I educate mothers about sterilisation of the feeding bottles and for preparation of rehydration solution. Sanitation of the village is the responsibility of Sanitary Inspector. He does nothing in the village. Similarly health education and immunization in schools is to be done by the doctor and female supervisor. She is also to bring the vaccine from PHC. My supervisor visits only once a month and does mere formalities. Last month she told me to update the records of ante-natal care to mothers and birth and death of children and status of immunization etc. but she did not tell me that the central team will also be visiting this village. There is no place in this sub-centre where we can come, sit, fill in our registers and keep our records. I do not know exactly the headquarter of my Lady Health Visitor nor I know the name of Trained Dai of my area. Health Worker (M) can tell you. Sometimes Sanitary Inspector also comes on the immunization day but I do not know much about him. I handover the blood slides, prepared by me and receive quinine tablets from him. We do not get any TA and do not always accompany the male worker. We are not expected to do so. He unnecessarily complained against me. My supervisor is lady health visitor. She has hardly visited the sub-centre".

(***Health Worker (F) 'B'***)

"LHV maintains the cold chain, brings in and preserves the vaccine for immunization. The sub-centre has a target of 120 family planning sterilization cases. Each staff member of the sub-centre including even the doctor, has a target of 24

cases per year. It creates a lot of conflict among workers. They grumble that doctors complete their quota by snatching their cases. It creates problems and sometime causes indiscipline. The quota of drugs supplied to sub-centre is very inadequate. Only 20 basic drugs are supplied in the beginning of the year and two supplementary supplied in between, which are very meagre. I am not at all in a position to provide the drugs required by the villagers. The quota is hardly enough for three to four months. How does one expect the Medical Officer to stay there and waste his time without any adequate supply?"

(*Medical Officer 'B'*)

COMMUNITY PARTICIPATION

The role of community participation is vital for the successful implementation of primary health care. Community participation provides for involvement of the people as partners along with health workers to identify health needs, and assumption of responsibilities to plan, manage and monitor the health activities and mobilisation of the resources required for it. It may include activities like educating people regarding health, promoting nutrition among mothers and children, arranging for safe water and village sanitation, promoting family planning activities and control of local endemic diseases. It involves mobilising community resources, coordinating efforts of village associations and participating in village health activities, through health committees etc. From these perspectives the role of community participation in the villages was studied. It was observed that in both the villages under study there were no Mahila Mandals, Youth Forums, Bal Mangal Dal, Nehru Yuvak Kendra and any other community forum except Panchayat. However, the extent and type of participation of the community in health matters was reflected through following statements from the community members:

"The Sr. Medical Officer had given me the task of initiating village health committees. Whenever I came I could not meet the doctor. I contacted the Sarpanch in village 'A' but I could understand that there were factions in the village and there was conflict and rivalry among them. No community leader was prepared to work jointly on a village health committee. An ex-Sarpanch narrated his experience of non-cooperation from the present Sarpanch and other caste groups in getting the loan for the construction of streets and pavements. I felt totally disheartened and did not make any efforts. The health workers also do not stay there and the villagers see no sense in such a committee which has no funds from the Government".

(*Block Extension Educator 'A'*)

"I do not understand what we can do for the village health programme. We have given Dharamshala for the sub-centre already. The government always wants to throw responsibility on the village community but when your staff is not working and not even attending the village, what can they do about it. As a community leader, I have taken the action to report to the CMO, but what?"

(*Community Leader 'A'*)

"The doctor and his staff hardly visit the sub-centre. Block Extension Educator

came to organise health committee thrice. He only expects us to arrange for tea and snacks and get family planning cases. They enjoy and go away. Nobody is interested in the welfare of the village community. I can assure all help from the community provided. CMO sees that his staff is regular and perform duties. We have no drugs in our sub-centre. The results of our fever slides taken by Malaria Workers are never reported back. Whenever the spray team has asked for our help, we have worked with the team without any payment. Our Panchayat has very meagre funds. If you really want us to participate in the health matter please send a good worker who stays in the village, leads us and tells us what we should do and how we should do. You see the Gram Sevak in our area is helping us in agricultural activities. He is very useful to us".

(*Community Leader 'A'*)

"I do not know what is the purpose of Nehru Yuvak Kendra or Bal Mangal Dal etc. There are no such clubs in our village. We have an 'Akhara' where interested youths of the village participate. There is no Anganwadi in the village. Only here sometimes mothers and children collect. It is supported by the government. Who cares for the youths in this village? Only the Sarpanch's son has some say. Sarpanch never wants us to do any thing for the village. Even the Panchayat meetings are hardly held. I do not understand what we can do about the health of the people in the village. It is for the first time that you are talking to us and enquiring about the activities which the youths can do for the uplift of the village health. I do not understand how we can help unless we get proper training and drugs. When are you going to train us for it? The committee business is all fan-fare. Even the Panchayat people fight minor things. You see, the well has to be cleaned, the road has to be built, drainage has to be constructed but who bothers for all this and where is the money? Any activity requires funds which are always in the control of Sarpanch. What will the Health Committee do even if few youths join together. The elderly people of the village will never listen to us. They do not bother for that. Fauji Master who is known to inspire the youth for welfare activities, started the construction of road and drainage for the village but has been unnecessarily harassed by Sarpanch. He is totally frustrated for any constructive action now".

(*Youth Leader 'B'*)

"Every activity in this village needs the support of Sarpanch or Gianiji of Gurudwara. Sarpanch is never willing to listen to us and Gurudwara belongs to Harijan Sikhs. Sarpanch does not give due regards to Masterji of Harijan Community. As such to get the support of Gurudwara is difficult because Gianiji always consults Masterji. In such a situation what the youth of the village can do through a village health committee. Our male health guide has been stopped supply of drugs by the PHC. The Health Department has no funds for the community work. You see the well in Harijan basti. It is covered and cleaned by adding lime, DDT etc. by our community. We have put a handpump in our area through our collective action but we cannot help the other side. Government does not really want the community to take the initiative. When we started constructing pavements, it was stopped by the BDO and Sarpanch. We have no sweeper in the village but you see

how clean are the streets in this basti than those in other bastis".

(***Youth Leader 'B'***)

"I was the only female member of the village Panchayat. Sometimes I raised issues about village sanitation and women's education in the village, but male members of the Panchayat never paid any heed to my suggestions. The Sarpanch being a Rajput does not like ladies to come forward and join in community activities. I got totally frustrated and withdrew myself from Panchayat. Even the village dai and health guide whom I recommended to the doctor for training were not selected, and the dai who is trained is not at all popular in the community. This village is male-dominated and the women cannot do any thing without their consent. No lady in the community can come out of her house for common cause and form any 'Mandal' etc. We, Harijan women together do Kirtan in Gurudwara and give all help to the Anganwadi programme in our area. What more can we do? We never get funds and support from the Panchayat Leaders".

(***Lady Community Leader 'B'***)

"I belong to this village. My children also come to this Anganwadi Centre. 'Bahenji' in-charge of this anganwadi comes from Kharar on her motor cycle. There is another lady who acts as helper to her. She being a female worker, requires a week's regular holiday every month. During those days she cannot cook food etc. In such days, whenever centres' Bahenji informs I or other ladies of our basti come of their own and assist her in cooking and maintaining the children. We do not get any money nor we want any, we are happy to see our children going well in the Anganwadi. There are such other opportunities where we can join with the government workers for promoting welfare of our village community. We also often go with the Chhoti Doctorni (Trained Dai) to the field. This is how we women can help".

(***Village Lady 'B'***)

"The Block Extension Educator was given the responsibility for initiating health committee. He informed that village conflict and rivalries are too large and too many. No community group was prepared to constitute a health committee and work jointly. Construction of road and lanes is held up because of non-cooperation. Moreover as our health workers do not stay in the village, the villagers do not see much sense in such a health committee. They want only a doctor in the village who should be available and provide them care in time of their need. He should be able to supply the medicines particularly injections to the villagers. In the absence of health staff the villagers are not at all interested in any health related activity. Definitely in ICDS village the community differences are here, but as the benefits are obvious, they are willing to participate in the Anganwadi which are located within their own community. On observation, it was found that ladies were actively participating as sub-centre helpers to Anganwadi workers without any grudge, whenever the regular helper was not present. The community has very happily provided good facilities and buildings for Anganwadis but not for the sub-centre".

(***Block Medical Officer***)

To understand the support and guidance being provided by the Supervisors at various level and perception of the District and State level officials regarding the effective delivery of Primary Health Care Services, it was considered essential to have their opinions and views:

"I am working at this sub-centre since 1984 and in this very premises. I have repeatedly written to Senior Medical Officer (SMO) and Chief Medical Officer (CMO) but nothing has happened. You can see that I am sitting in such a dingy condition, with no equipments, furniture and basic amenities to work. Sub-centres are established for political reason. Panchayat hardly takes any interest to provide a suitable building. What job satisfaction can I have? Drugs are always in short supply and irregularly provided by the health authorities. We have no budget and the total amount earmarked for drugs for a sub-centre is Rs.3000 per year. Mostly, I have to prescribe and suggest to the patients to buy from outside. Initially I tried to be regular in my attendance but I found that the patients did not turn up just to get the prescription. I feel frustrated and helpless and I admit that I just come for sometime and leave the dispensary. It is known to my Sr. Medical Officer. The major concern of Sr. Medical Officer is getting the family planning targets to be completed. With the help of my workers I had been able to complete our targets but because of interference of other departments, my health workers became demotivated. Now they do not want to work. Our Director repeatedly tells us that our job is preventive and promotive but it alone does not work unless supported by adequate curative facilities at the sub-centre and good referral services and after care. The villagers expect us to provide all sorts of drugs and get rid of the sickness but it is not possible. Moreover, family planning is the only programme on which authorities give stress. It is very badly damaging the other health activities of the sub-centre. Moreover, the business of completing targets is so useless that we hardly touch actual target group with two or three children for accepting sterilization.

There is no refrigerator to store the vaccines. Only on the EPI day LHV carries the vaccine to the required village and provides the same. I do not come in the picture as LHV directly goes to the village without informing me at the sub-centre.

The Health Worker (M&F) have a separate room and hardly meet me. They have their separate attendance register. Basically, I control pharmacist and two peons. There is no post of sweeper and it is at the mercy of the peons to clean or not to clean the sub-centre. Sometimes they do take the help of some villagers to clean the surroundings. According to the policy, the doctors placed in the urban sub-centre are allowed to carry on their private practice, where they have all facilities at their command but whereas we who have to serve the rural community are discriminated for such benefits and placed at a place where no one would like to sit.

My major task is to serve at the MLAs hostel as instructed by the authorities. So far I have not received any guidance from the Sr. Medical Officer nor he has visited, this sub-centre earlier. It is only today that she has come to meet the team".

(***Medical Officer 'A'***)

"After obtaining my MBBS degree, it is my first posting in this sub-centre. This sub-centre is temporarily located in one of the back room of a temple, which is used

as night rest house for the labourers. I had been given assurance that soon a sub-centre building will be built and with this hope, now I have completed two years and I don't have any hope of the sub-centre building in the near future. I have not been provided any facilities ***i.e.*** office furniture, and instruments and facilities for properly checking patients. Department has forgotten and panchayat is not at all interested in sub-centre activities. Even the basic amenities ***i.e.*** drinking water, toilet, electricity is not there. Except one health worker (M) all staff comes from Chandigarh to Mohali.

Out-patient department attendance is very poor. On average 8-10 patients with only minor ailments visit per day. Moreover we don't have sufficient medicines. Hardly drugs worth Rs.3000 are provided in a year, which are not at all sufficient. Moreover the drugs are not sent according to the need of our sub-centre but as per the prescribed quota. Sometimes these are provided in the beginning of the year and then followed by supplementary supplies, which are not at all sufficient. On certain medicines/injections supplied to us, even the expiry dates were not mentioned.

Health authorities give much stress on programmes of family planning and immunization. As such other programmes get deferred. The proper functioning of the sub-centre is hampered by family planning targets, fixed for all from peon to Medical Officer. It results into a tug of war among us. Any person who visits the sub-centre is followed by peon to Medical Officer for family planning motivation. As such the people sometimes become allergic and suspicious of the staff. Even the team spirit among the sub-centre staff is badly damaged because of unseemly competition for achievement of individual targets.

Private practitioners are also badly damaging our image among the village community. They are living in this village and are available to them in emergency. Thus they have a better rapport with them. They also have much better working facilities ***i.e.*** clinic building, medicines and injections etc. whereas sub-centre is poorly located without adequate medicines. If we prescribe the drugs, people do not like it, as there is no drug store facility in the village where they can buy. Medicines not being available from sub-centre, people are not interested in our preventive and promotive services. They openly charge us for a heavy burden on the governmental expenditure with no outcome.

Sometimes we too feel that way but the fault is not ours. It is the government's wrong policy to open a sub-centre without any proper building and facilities. If we really want to serve the community, I suggest that before opening any sub-centre, building and staff quarters must be built or acquired and essential facilities ***i.e.*** furniture, diagnostic instruments, sufficient essential medicines/drugs and quarters for the staff should be more available in the sub-centre village. Facilities like vehicle at least once a week by rotation be provided to sub-centre staff by Medical Officer (PHC) for moving out in a team to other villages under it. Special allowances be provided for staff working in the villages".

(***Medical Officer 'B'***)

"The doctor at this sub-centre has political affiliation and mostly sits in MLAs hostel. I am not able to correct him. Earlier I tried to put some check on him, but it was of no use. Therefore, there is no point in visiting this sub-centre.

Moreover, I have not been able to get the sub-centre constructed as the 'anchayat is unable to provide a matching grant, except the land. Doctor often :omplaints about the meagre space and facilities.

The female workers generally work in the sub-centre village only. They do not move to the other villages of the sub-centre as they do not get the travelling allowance. Health Worker (M) gets it. Unfortunately, the supply of drugs is inadequate. Many drug bottles even do not indicate the expiry date. I am aware of it but have no control over the supply.

Our major task is on completing the target of family planning and immunization which these workers are always able to achieve. Other programmes are left. I cannot help it, unless there is good sub-centre building and quarter for staff and they stay over there.

The sub-centre is allotted targets for the family planning and immunization. The sub-centre staff was told in the last monthly meeting about. Luckily immunization work goes as well as my LHV has her personal refrigerator and she stocks the vaccines at her home.

Sub-centre services are just an eye wash to the village community. You can see that the private practitioners are there and having a good practice. It is better to close such sub-centres.

"We are opening new sub-centres every year with all medical and para-medical staff but generally the OPD attendance is nowhere more than eight to ten patients per day, which can even be handled by the well trained Health Assistant (F)/Lady Health Visitor or other para professionals. We are unnecessarily wasting medical resources by posting Medical Officers at sub-centre level. Young doctors even when provided with suitable working conditions, do not stay at the sub-centre and run away. The difficulty is that they can treat only cases of minor ailment with drugs supplied to them, otherwise for acute or chronic cases they have to tell the patients to buy drugs from the market. They cannot supply the drugs. Villagers do not like it. If doctors start supplying drugs from their own against payment for it, they would considered to be including in wrong practices. Therefore when drugs are exhausted in the sub-centre the doctor has to be away from sub-centre. Why should one blame the young doctors, as per routine he does not even meet the workers daily. They go to different villages on week days. He has no official vehicle to move about for meeting the workers in the community. So he hardly finds any worthwhile work for himself. The family planning is the only programme which draws everybody's attention. At the sub-centre how much preventive and promotive work could a doctor do every day. I have only posed the problems or questions which need to be considered by the authorities".

(Senior Medical Officer 'B')

"We feel that Health Workers (Male and Female) must stay in the villages, if you want any improvement in the health conditions of the rural people. Their stay in the village should be compulsory. They must be provided basic facilities like good constructed sub-centre building, residential quarters and transport facilities for

proper movement in the villages under their jurisdiction. Now you can well imagine in the present time, our worker travels on cycle from one village to the other. By the time they reach the client, they are fully exhausted and not in a position to speak properly and influence or motivate him. Unless they are welcomed they cannot influence the community nor acceptance of health services in the community could be expected? In contrast, private practitioner is maintaining a scooter, decorated shop with lot of medicines and injections, despite the fact that he is not qualified enough for private practice. He is more impressive to the village community. We should improve the status of our health worker. If we provide moped they can move faster and people will show respect to them. Even our health worker, compared with other village functionaries *i.e.* Patwari, cooperative bank clerks or school teachers, feels his status lower than that of others. These young workers' position is worst in the village. You look to the senior functionaries of the sub-centre. The poor doctor is sitting in a room of a Mandir/Dharamshala/Panchayat Ghar without basic amenities like electricity, drinking water and toilet, very poor furniture and no provision of separate room or screen for examining the patients etc. In contrast you compare the Headmaster/Headmistress of the Government High School or Manager of the Bank with beautiful building, and all type of comforts and amenities. Moreover the doctor did neither have sufficient medicines for his patients, nor medical equipments for examining him. Therefore, even sufficient patients do not visit the sub-centre whom he can examine. You can well imagine how demoralised he will be.

Trained dais are performing good services to the village community, they should be given some good incentive/honorarium, because they assist our staff at sub-centre also. Their incentive must be raised, they are the real basic health workers in a village level who actually live in the villages and are available for the community for twenty four hours.

Male workers are given fixed OTA every month under 'MPW' Scheme because male health workers have much larger coverage as compared to the female health workers. Therefore we pay fixed OTA to them. For health worker (female) we have a channel of promotion, she is also sent for training. Next promotion is Lady Health Visitor and then Senior Lady Health Visitor. But for health worker (male) there is no channel of promotion so far in our State. But we are thinking that if we also give them training and create a channel of promotion as Health Inspectors there may be a scope for them. But likely vacancy of supervisory position in the near future is very little in the State.

(***Chief Medical Officer***)

FEW CASES OF COMMUNICABLE AND NON-COMMUNICABLE DISEASES

If the case of communicable diseases could be identified at the earliest stage and proper preventive measures are taken, their spread in the community could be controlled and the patients could be treated much faster. Moreover, with the proper health education they could be taught how to prevent and cure these diseases further in the community. However, no such efforts were seen to have been undertaken by the health workers as indicated in the following few cases, though the primary health care approach has given the highest priority to health education and preventive measures.

A Case of Tuberculosis

Ram Singh, an old man of 65 years of age, living in village Sajanpur was suffering from TB and exzema for the last few years. This case was attended by the Health Worker (Male) alone on two occasions and was advised to visit the sub-centre for his treatment. But during his visits to the sub-centre this old man could not be attended by the doctor as he was never visiting the sub-centre. With the result he was disappointed and lost his faith on the health services provided in the village sub-centre.

The old man is living in one room alongwith five family members. The same room is used for all purposes *i.e.* cooking, eating and sleeping etc. No special precautions were observed by the patient. He is not even aware that this is an infectious disease and can also affect the other members of his family. This indicates that the basic parameters of health education were completely missing. It clearly shows that no health worker visited the area atleast to educate him and his family about preventive aspects of tuberculosis and tell him that he can be cured, provided he takes the medicine regularly.

A Case of Scabies

Radha a young girl of eight years residing in the sub-centre village was suffering from scabies. She had supprations all over her body and pus was oozing out. She was wearing a dirty frock and looked as if she had not taken bath for the last so many days. She was scratching her body and simultaneously scratching her head. A few other children were also playing with her.

Her mother who was not present at that time also came and enquired about the treatment of her daughter. She complained in the presence of health workers that nobody ever advised her to give regular bath with boiled ***neem*** leaves (as suggested by you) nor suggested using any lotion or ointment. She said that sub-centre needs to be closed down as nobody is there to serve and provide any medicine etc. She narrated that Registered Medical Practitioner in the village advised her to get his treatment. He would give drugs for a few days but she did not like the idea as she could not afford it. She also visited the sub-centre once when her daughter had a few supprations but nobody gave any medicine nor advised anything at that time.

"I can show you a few more children, who have also got scabies like my child. Health Worker (Male), being questioned, said they had no drugs with them at sub-centre and was also awfully busy in family planning activities. Moreover these villagers do not come for our advise in sub-centre"

A Case of Bloated Stomach

Bantu, a ten years old child of village Sajanpur, was suffering from perhaps enlarged liver problem from his childhood as his stomach was very much bloated. As a result there was swelling on his face and eyes were very pale. The child had stunted growth and looked like a child of 6-7 years. During his illness, since seven years, no health worker ever visited the family. Sometimes the mother of child took

him to the sub-centre for his treatment but that the child had no adequate treatment and has shown no sign of improvement.

Bantu belongs to a low income family, living in a single room which has only one entrance door with no ventilation. This room was found to be used by the family for all purposes, *i.e.* for sleeping, cooking and also providing shelter to their cattle etc. On probing it was found that they don't have even basic knowledge of health education, although they were keen to know about it. Surprisingly these type of families who are interested to know about the basic concept of health are totally ignored by the health workers. Mother of the child is concerned about the treatment of child but she is unable to meet the cost of treatment of his child privately and she has no hope to get the treatment from the sub-centre.

Being informed that she could carry her child to Bash PHC where he would get necessary care, she just could not believe. She told us to leave her and her child to their fate as God alone could help her".

A Case of Blindness

Pritam Singh, age 60 years of village Sajanpur had an eye operation a year back in an eye camp and since then he has been suffering from blindness. Since his operation nobody has come to him check his condition and given any advise. The old man now has lost all his hopes to get cured. He had no one in family to support him. He complained that no health worker has ever come to help him.

Crazy for Male Child - "A Pregnant Mother"

Rajo, aged 38 years of village Sajanpur is a mother of five living daughters and is expecting sixth child any moment. This is her eight pregnancy. She had already lost two children earlier. She does not have any male child. Because of this both husband and wife were avoiding use of any family planning method. According to her mother-in-law, grand son is a must for the family. Till then they are to carry the hope of getting a male issue. She is not even ready to accept the advise of ANM to immediately remove her daughter-in-law for hospital for safe delivery. She feared that hospital people may not perform sterilization along with the delivery.

That day, Rajo was having bleeding. It was a highly anaemic case. She was unable even to lift herself from the bed. But totally unconcerned, her husband who was also available at home and is working in PGI, Chandigarh did not bother to seek the medical care. He was not at all willing to call any doctor or send her to hospital even if she died. A member of the Panchayat and others who were present at that time advised him to take his wife to hospital for safe delivery but it looked as he was adamant to his decision and would go according to his family tradition. A male issue was uppermost in his mind and he was not ready to take her to hospital where his wife would be operated, so he thought.

The Health Worker (Female) who examined her in the presence of team, repeatedly advised to send the lady immediately to the hospital and she offered to go along with her but the family resisted and told us all not to bother them.

An Incident

A surprise visit to the sub-centre was made at 9.30 A.M. in November, 1986. The sub-centre was locked. Doctor-in-charge was about to leave the sub-centre. On enquiry he told that he had a school health programme in an adjacent village and the health worker (female) had already gone to the village to inform and to accompany a family planning case of sterilization to General Hospital, Chandigarh. In the previous day also she visited there but the person was unwell. Therefore, she would like to accompany the case from the village to the hospital. She was not visiting the sub-centre for the last two days. Other health worker (male) was also out in the field. When asked for the movement register he handed over the attendance register, and stated that she did not have the advance tour programme of health worker (male). She further reported that the peon of the sub-centre also had gone in advance to school, and she was also just moving out for school immunization programme. A glance into the attendance register revealed that all the workers were marked as present. The doctor further reported that workers were informed verbally to go to the field on tour and he marked their attendance accordingly. He explained that generally the sub-centre was not closed as today. It was because of pharmacist being on maternity leave. She always remains in the sub-centre during the field visits and the doctor left for his said visit. In the meanwhile, peon turned up and felt sorry as he was late. After about 10 minutes health worker (male) also came to the health centre, who was already in the sub-centre village since morning and doing home visits. He had come to the sub-centre because he had already seen our jeep passing by the house he had gone for visit.

We took leave of the doctor and went to adjacent village to meet trained dai and to know the whereabout of health worker (female). She told that there was no programme of health worker (female) in that village on that day, rather she visited that village three days back and had met her also. Later, while we were talking to community leaders over there, we found doctor-in-charge also was arriving there following us. To our surprise there was no school health programme in the village. Doctor became nonplussed. He said "I had to give wrong statements, in order to save my staff. I was hot aware that you would cross check and visit the village to make an on the spot verification. I am sorry for all this".

(*Village 'B'*)

Doctor is not in-charge of sub-centre. This is inconsistent after having discussions with all categories of staff at the PHCs and sub-centres, it was felt necessary to collect views/opinion of the State of Punjab. The discussion held was reproduced below:

VIEW OF DIRECTOR HEALTH SERVICES

Director of Health Services was briefed about the two sub-centre activities to which he expressed his views as under:

He acknowledged unless doctor and his field staff stayed in the sub-centre village the health services could not improve. But unfortunate part is that most of the doctors and the staff do not stay there. In governmental set-up we work in a set

structure and we cannot change it. I cannot force the health staff for compulsory stay in the village. On the other hand, Registered Medical Practitioners have an upper hand over the sub-centre staff because they are mostly staying in the villages and very closely mix up with the community.

The choice for location for sub-centre village is beyond the scope of health department and therefore, the facilities which could be easily provided by the community are not forthcoming. Its merely by chance that the selection of both the sub-centres which you have studied, are representative of poor centres.

The village community still continues to be traditional in outlook. He narrated his own past childhood experiences and reiterated that those still hold good today in the village society. He affirmed that cattles were more important to the village community than other things and therefore they need to be protected and looked after and therefore you find the first verandah/room of a village house always used as a cattleshed and other rooms behind are for the family.

Similarly, there is no doubt that the preference for the male child is still very high in our society. No family is considered complete unless it has a male child and even if the PGI employee about whom you talked also desired accordingly, it is not at all unnatural and out of context.

As regards the maintenance of records and diaries by the sub-centre staff it is a Statewide problem. Due to lack of sufficient funds and supply of stationery, required registers, diaries and forms etc. have not been supplied in time. Therefore, you could find the records are not very uptodate. Similarly, we could not supply the refrigerators at the sub-centre level and therefore if somebody points out about the maintenance of cold chain we are aware of our limitations. However, our ANMs are trained to return the used left-out vaccine to the LHV who can carry it and keep it intact at her home in her own refrigerator, and again bring when needed in her next visit.

Regarding utilisation of beds by the rural community, you will find certain centres having four beds but they are being overutilised, but at certain community health centre which have 20 beds but hardly a few are utilised. If you ask my opinion only sub-centres should be opened at such places, where those could be utilised. But this is the tragedy in a democratic set up which we cannot help. Health facilities are created on political considerations rather than on real need.

EMERGENT ISSUES AND RECOMMENDATIONS

Issue - 1: Image of Sub-centre Health Services

Health personnel at all levels recognised that the image of sub-centre services was very poor in the community.

The entire thrust of health care services at the village level and sub-centre level is confined to achievement of the targets set for family planning and immunization. Other health care activities are being seriously neglected. Non-availability of doctor purposefully discourages the field staff to refer any case to the sub-centre. It has led to failure of development of any referral to PHC and above. It has created a negative

attitude in the community and is highly appreciative about the role of private practitioners of indigenous system and the trained dais, regarding their availability, support and services and immediate attention given to emergencies.

It has led to their total dependency on the RMPs or in case of emergency on the general hospital in the Union Territory of Chandigarh. The community perceives the role of health functionaries only in the context of family planning and nothing else and generally tries to avoid them. The doctor's image is so poor that he was not even invited in any village functions.

Recommendations

Health organisation should ensure the availability of doctors and basic drugs essential in emergency situations. It will enable the building of community confidence in the health services and then only the referral system could be developed systematically and subsequently improve the image. The Medical Officer of the sub-centre should join in the meeting of village health committees and other village functions to solicit acceptance by the community.

Issue 2: Facilities of the Sub-centre - Building

Both the sub-centres do not have the buildings of their own. They are located in sheds of a temple and in a room of a Harijan Dharamshala. The accommodation is too scanty for functioning of the sub-centre and no basic amenities are available over there. Further, these accommodations are temporarily provided during the day time. In the night, the arrangements are disturbed and used for the boarding purposes of the labour-guests of the Sarpanch. It unnecessarily requires the peons to rearrange the office every day which they grudge.

Though the land has been provided by the Panchayats in both the places long back but they will not be able to contribute 50 per cent of the matching grant for construction of the building. Therefore, there is no prospect in immediate future to get the building ever constructed. It affects the functioning of the health staff and they feel demoralised, particularly when there are very good buildings for schools constructed by the government itself.

Recommendations

It is recommended that government should review the issue of matching grant to be given to Panchayat for construction of sub-centre building and take the total responsibility of constructing the building for the sub-centre and the staff quarters, according to the specified strength of all categories of staff posted over there so as to ensure their availability to the village community.

Issue 3: Facilities at the Sub-centre - Drugs and Equipments

The total lack of basic facilities and equipments frustrate ever those Medical Officers, who are willing to work in the rural areas. One of these Medical Officers pointed out that initially he tried his best to be regular and attend to health care needs

of the community but because of poor and irregular supply of drugs and even such facilities like an examination table and room to sit, he also got demoralised and developed an apathy for the job. It further adds to their frustration and demoralisation when PHC and district level officers totally neglect them and leave them to their lot. Both the Medical Officers felt that during their stay in these sub-centres the district staff visited for the first time. The Senior Medical Officers (PHC) seldom visited. It is hardly once or twice in a year. Even problems then brought to their notice have neither been considered nor solved. Everybody in the situation felt helpless.

The doctors pointed out that the annual supply of drugs to the sub-centre in two instalments were hardly sufficient for two or three months. Afterwards if they prescribed the drugs and could not supply them from the sub-centre the patients cursed and stopped visiting the sub-centre and accepting health care services and advices. I need to be seriously looked whether a Medical Officer is at all required to be posted for such a small population of a village sub-centre.

Recommendations

Though Medical Officer of a sub-centre is expected to promote preventive and promotive activities, he becomes professionally ineffective and frustrated without a proper support of curative services.

From cost and benefit point of view, it needs to be critically examined how viable and cost effective this arrangement is. According to rough calculations, the annual total cost on salaries comes around 1.25 lakh for the staff against the supply of drugs and equipment worth Rs.3,000 per annum, for the sub-centre. If the cost at the supervisory level of the services is considered, a huge margin of wastage occurs. Moreover, obviously doctor is not participating at all in providing promotive and preventive aspects of health care. If the government really wants the doctor to carry on the preventive and promotive services, he needs to be thoroughly inducted and given mobility with a definite programme to cover all the villages under his jurisdiction, with a proper monitoring and support system from the PHC and district level.

Issue 4: Making Functionaries Available

It has been repeatedly reported by all concerned that the non-availability of health staff particularly doctors in the sub-centre is very critical. Further the doctors and most of the staff are also not paying visits in the community, so as to know the health problems of the area and to work for generating community action and mobilising the additional resources and facilities. Most of the health functionaries in general, barring a few, are non-entity for the village community.

Being with the village community and visiting their places it was observed that patients suffering from various diseases for long had never been approached/visited by any health personnel nor given any advice for their health problems. The community did not recognise sub-centre as an utility service. On the contrary, private practitioners and indigenous health workers had greater rapport with community and played an appreciative role. It was also brought to our notice by the community that none of the senior health personnel of PHC or district had ever

visited their sub-centres and talked to Sarpanch or other community leaders within their knowledge.

Recommendations

There is need to initiate the monitoring of sub-centre activities by the PHC and district officers. The concerned Medical Officer-in-Charge of the sub-centre should be held accountable to the Panchayat and Senior Medical Officer should ask for the opinion of the Sarpanch regarding the activities of health functionaries of the sub-centre. The State authorities could consider the proposal to hand over the sub-centres to Panchayat Samitis for effective implementation of health care.

Issue 5 : Planning and Monitoring Sub-centre Activities

It was observed that all the functionaries of the sub-centre were performing their duties in a very casual way. The Senior Medical Officer, PHC recognised the need of planning the activities at the sub-centre and his health worker (male and female) also felt enthusiastic about it. But they told that camp approach and special month approaches disturb even their planned tour activities. It has led to adhocism in planning for performance.

Recommendations

The entire survey data available in a sub-centre should be analysed to determine various health needs and trends for the sub-centre population. Accordingly, in collaboration with village trained dais, health guides and health workers, the targets for various health programmes should be set and the progress should be monitored with timely remedial action whenever required.

Issue 6: Performance of Various Health Functionaries

The Health Worker (Female) does not accept to visit other village than the sub-centre village as she is not entitled for any travelling allowances like male health worker. The completion of family planning targets overrides in the minds of the workers. The entire monitoring and progress review is for it. The other functions are being deliberately neglected by them. The role model presented by the Medical Officer of sub-centre and the senior supervisors of the primary health centre discourages to do any work and promotes absenteeism. The LHV confines herself to supply the vaccine for immunization for which she has the facility to store at her residence. She neither supervises the work of Health Worker (F) and trained dais nor she visits the community frequently. All the categories of health personnel are trying to look after his or her own personal activities around their residences. They have no concerns for the sub-centre services nor for the community under their jurisdiction.

Their records are totally incomplete and there is no system at the PHC to verify the field data reported to them by the sub-centre. The OPDs are conducted but attendance is very thin. Health Worker (F) only conducts certain deliveries but does not conduct any regular ANC checkup.

Recommendations

There is need for policy decision to provide Field Travelling Allowance to the lady health worker at par with the male health worker.

The role models of the Medical Officer at the sub-centre needs to be corrected. He needs to be regular.

The monitoring and feedback system for all health care activities at PHC and sub-centre level needs to be streamlined and strictly adhered to. Special emphasis should not be given to selected programmes at the cost and neglect of other health programmes. The district supervisors should look into it.

Orientation training programmes should be held for personnel ranging from district to grassroot level to clarify their roles and responsibilities in context of primary health care approach.

Issue 7: Coordination Among Different Health Functionaries

The Health Worker (M) and Health Worker (F) prepare their joint tour programmes and make home visits only when pressed to complete the family planning targets, otherwise they prefer to work independently. The trained dais cooperation is also sought for it. Health Worker (F) seeks help of trained dai for immunization camps as well. Otherwise, coordination with other health functionaries at the grassroot level was not there. Even in the village of ICDS block, the health worker (f) was only coming to Anganwadis on immunization day to provide immunization as per schedule otherwise she was neither having any rapport with the Anganwadis workers nor seeking their cooperation for other health activities of MCH and family planning. Both the villages did not have their health committees. There were no workers from other sectors, except Chowkidar in both the villages. He was functioning of his own and health worker at the sub-centre level met him or utilised his records. They did not consider his records as an important source of data on vital statistics.

The PHC headquarter staff had entirely neglected the sub-centre and there was not even the formal linkage between them as the Medical Officer of sub-centre attended the monthly meetings held at PHC rarely.

The relationship of health functionaries with other block level functionaries like Patwari, Gram Sevak, Police Constable at the sub-centre level was not congenial and they did not like to associate with them because of the conflict and discredit which health workers received in achieving the family planning targets. There was no interaction between Medical Officer and private practitioners who were generally critical of the sub-centre services.

Recommendations

Any coordination inside or outside health sectors at sub-centre level is possible with the availability of medical officer who is a person really interested in preventive and promotive aspects of health care.

The support and supervision on the part of the Senior Medical Officer of PHC

needs to be strengthened and systematised to encourage coordination at the grassroot level.

The Senior Medical Officer should ensure the formation of village health committees, thus enabling the Medical Officer of sub-centre and his other functionaries to collaborate and coordinate with the Block Extension Educator.

The health functionaries at the sub-centre should be sensitised regarding the records available with the Anganwadi and village Chowkidars and even with the Panchayat relating to health problems and how to use it effectively.

Medical Officer of the sub-centre should be made to hold monthly meetings of all the workers under him alongwith trained dais, health guides, anganwadi workers, school teachers, adult education instructors, chowkidar, gram sevaks and other functionaries of development sector positioned locally. In addition to this, organisers of voluntary agencies should also be invited to coordinate health related activities at village level.

Issue 8: Functioning of Anganwadis

The Anganwadi workers were found to be really dedicated and sincere to their duties. Their supervisory and recording system is also adequate. The necessary support and supply is always forthcoming. However, the two Anganwadi workers are working in total isolation because of social and religious considerations. The Health Worker (F) of the area who comes only for immunization is not acceptable to the community as she is irregular. The villagers questioned as to why Anganwadi workers are not being trained for giving immunization. The children were found to be looked after well by the Anganwadi workers and their records were uptodate. It was observed that the day the helper did not come, the village ladies provided the necessary assistance to Anganwadi workers.

Recommendations

The Medical Officer of the sub-centre should develop interaction with the Anganwadi workers and visit them and provide them guidance regarding health matters and ensure the services of Health Worker (F) at the Anganwadi regularly on EPI days.

The scheme needs to be promoted in all the villages as it offers an obvious focus for the community participation and community action on the part of the women.

Issue 9: Records System

The State has adopted an integrated recording system under Multipurpose Workers Scheme. However, no registers were found to be uptodate at the sub-centre level. Even the attendance register for the staff was incomplete and not regularly signed by the staff. Any of the functionaries present at the sub-centre marked the attendance 'A' or 'P' on it.

The daily diaries maintained by the field staff are also very sketchy. They write

about the villages visited or total number of immunization or family planning motivation cases contacted. The record shows only the figures *i.e.* total number of cases from which no inference could be drawn.

The eligible couple register was found totally incomplete for the last so many months. The health worker reported about the short supply of stationery and therefore they had to stop maintaining the records. They also told the team that district authorities have issued them instructions only a few days back to complete their records before the team arrives but as they could not update them, they did not show to the team. The Medical Officer of the sub-centre informed that each worker prepared his or her monthly report and send it to the respective supervisor directly told him verbally. No reports could be available at the sub-centre. Even the tour programmes of the health workers (male and female), if any are sent to the PHC for approval without the kowledge of the Medical Officer sub-centre.

Recommendations

The Medical Officer-in-Charge of PHC should direct the field staff of the sub-centre to submit their reports and returns of Medical Officer of the sub-centre who after due scrutiny should forward the same to the Medical Officer, PHC.

The Medical Officer of sub-centre should sign all the registers maintained by the workers and review the daily diary of health workers every month and record necessary feedback therein.

One to two per cent of the total visits made by the workers entered in their daily diaries should be randomly verified by the Medical Officer by making a follow-up visit in the villages.

The Medical Officer of sub-centre should direct the health worker (M) to contact the village Chowkidar to get the vital data of birth and death records.

The attendance register should also be signed by the Medical Officer concerned and timing for coming and going should be mentioned.

Issue 10: The Status of Health Education in the Community

It could be noted from the above cases that community awareness regarding health facilities available at the sub-centre was very little. Moreover, the health functionaries were miserably failing in providing health education to the community and they were least aware of the diseases that could be cured and prevented.

Recommendations

From a study of the cases reported it was observed that no effort was made to provide health education to the community, and the family by any of our health staff posted at sub-centre, nor had they suggested even at this stage any preventive measures by the community. Therefore, it is suggested that the primary health centre staff should be given orientation in health education for communicable diseases at the earliest.

There is a need to develop a monitoring system for health education activities being performed in the field.

Block Extension Educator from the primary health centre should visit sub-centre monthly and educate the health staff in relevant health messages. He should also address the community through group and mass meetings.

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